A pretty little mulatto boy not fourteen, with no outward blemish, shyly whispered to the doctor, who answered,—

"By all means, Quasshie, show the visitors your costumes."

Then they led us to another pavilion, bright with the inexhaustible sunshine, and from a great chest this hobgoblin crew pulled out gay cotton robes, tinsel crowns, and a sceptre.

"It's 'Richard the Third,'" murmured the doctor. "They played it at Christmas. Yes, I drilled them myself and designed the clothes; they sewed them."

"Missus, I was de queen," said a faceless creature with happy pride. ("He wore a mask," whispered the doctor.)

One limped forward, saying, "I was de Duke ob Buckingham."

"Dis is de king's crown; I wore it." This player lacked hands, but managed, with stumps, to hold out the crown for us to admire.

Quasshie, the pretty little mulatto boy, roguish, merry, doomed, had been cast for a messenger.

The patients seemed as little conscious of misery as the doctor of danger. Nothing could have been more matter-of-fact. His business was to study the disease and care for its victims, that was all. Moreover, the experience of many years convinced him that intelligent precautions minimize the chances of infection. Dr. N. has not yet discovered the bacillus of leprosy, but declares that he lives in hopes of doing so, and perhaps living in hopes may be, on the whole, as helpful to the lepers as dying for them.

FEEDING AND THE USE OF RESTRAINT IN CARING FOR THE INSANE

(Continued from page 4)

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SECOND PAPER—RESTRAINT

THE question of the use of restraint in the care of the insane is one about which there has been and still is a great deal of discussion. In former days much restraint was used, and that very inhuman and often unnecessary. Let us be thankful that the days of the chain and the anklets are forever gone in all civilized countries. Many authorities hold that no mechanical restraint should be used, and rely entirely on the strength, forbearance, and even temper of attendants and nurses in controlling violent or suicidal patients. Others hold that manual restraint allows opportunity for, and even invites, abuse on the part of

the attendants towards their irresponsible but oftentimes very trying charges. Manual restraint of excited and violent patients often makes them worse, and they struggle more than they would if safely secured by some harmless but effective mechanical devices. The golden mean between artificial and purely manual restraint seems to many the safest. It is certainly rarely feasible to care for homicidal and suicidal patients in acute stages of disease without other restraint than manual, as it is seldom possible to afford the number of attendants necessary to keep the patient from harming himself and others. An excited patient will easily exhaust two or three strong nurses if they are not allowed to use mechanical restraint.

Restraints are indicated and advisable in the following cases:

In acute maniacal conditions, where patients are rapidly exhausting themselves by their constant motor activity, strength may be preserved and the patient tided along until the mental excitement subsides. In depressed conditions where the patients have active suicidal tendencies it is often the only way to save life, since such a patient can and will take his own life if vigilance is relaxed for an instant unless he is secured in some safe restraint.

For the patients who are habitually violent, seclusion in rooms by themselves is often bad, and by judicious use of restraint when their violent tendencies are manifested they can be kept safely among others.

Self-mutilation, habitual and constant masturbation, destructive tendencies, and denudation of the person often call for some form of restraint to protect the patients from inflicting serious injury upon themselves. Old and feeble senile cases who are restless often need some mild form of restraint to prevent them from getting out of bed, falling on the floor, and breaking bones or inflicting serious bruises.

The suicidal and exhausted cases are often restrained in bed by either the so-called bed harness or bed sheets. A bed harness consists of a leather pad to which are attached strong webbing bands, which are fastened to the sides of the bed by strong ties. A waist-belt is secured to the leather pad and buckled about the patient. Shoulder-straps also pass from the leather pad over the shoulders of the patient and are fastened to the waist-belt. Padded anklets attached to the webbing bands secure the feet in position but allow considerable freedom of motion. Before placing the patient in such a harness it is necessary to put on a light camisole, so that the hands may be tied to the side of the bed. Patients are generally comfortable and safe in this restraint, but it is complicated and easily broken and often gets out of repair, so that many institutions prefer a bed sheet.

This is a stout canvas sheet, cut a little larger than a single bed,

made double, and stitched firmly about the edges. Along the sides and ends are placed at intervals of eight to twelve inches strong ties or heavy tapes, by which the sheet may be fastened securely to the rails of the bed. At the top of the sheet a semicircular piece is hollowed in to allow the patient's neck to pass out. To the end of this sheet and stitched in firmly along the front of the neck and body part is a camisole. This camisole is first put on to the patient, laced up, and the arms secured to the side of the bed by ties through the eyelets in the ends of the sleeves. Then the sides, top, and bottom of the sheet are tied securely to the bed-rails by the firm tapes. In this restraint soiled linen may be changed by loosening the lower half of the sheet only. By fastening both arms to one side of the bed a change of position may be secured. This is, of course, a great advantage if patients are restrained long at a time.

A camisole is used generally for violent and destructive patients, or for able-bodied patients whose tendencies are actively suicidal, and yet who do not need bed restraint. It consists of a fitted waist, generally laced in the back, with long sleeves which extend over the hands and are closed at the ends. Eyelets are placed in the ends of the sleeves so that the arms can be crossed and secured by tying behind the back if necessary. This camisole may be made of soft canvas, stout unbleached muslin, drilling, or denim, and should be made double, the seams turned in so there will be no scratching, and firmly stitched, especially around the neck. It should fit well but not tightly.

For destructive patients who tear ordinary clothing princess dresses with closed sleeves, made of stout linen, denim, or soft canvas, are often used. These should be buttoned or laced behind.

All patients who are in restraint require special attention on the part of the nurse. They must be bathed frequently and rubbed daily with alcohol and their backs powdered. The underclothing and bed-linen must be kept perfectly clean, smooth, and dry. If the patient become soiled by fæces or urine, he should receive attention immediately and the greatest care should be taken in cleansing and drying the parts thoroughly. The danger of bed-sores is always present, especially in old patients who are confined to bed for long periods at a time. A lotion made of tannic acid dissolved in equal parts of alcohol and water is of great use in preventing the breaking down of the tissues where there is continuous pressure.

For patients who are restrained in bed a frequent change of position is necessary to make them comfortable and prevent pressure sores. The nurse should never lose sight of the fact that restraint is only to be used when needed and by a doctor's advice, and that it should always be made

as comfortable as possible and taken off as soon as consistent with safety.

In the feeding and care of the insane infinite pains, tact, faithfulness, and patience are needed. No nurse should undertake such care with the anticipation of success unless she is willing to give these in full measure. If she does bring such qualities to the work, success is assured, and she will earn the gratitude of patients, friends, and the physician for whom she nurses.

MOUTH-BREATHING—ITS INJURIOUS EFFECTS

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THERE is no perverted function attended with so many ill effects, and none persisted in so continuously and with as little concern, as that of mouth-breathing. In proof that man was intended to be a nose-breather we might cite the authority of divine writ, when it says, "The Lord breathed into his nostrils the breath of life," which shows that the ancient Jews had a proper conception of the nose as a divinely appointed organ of breathing.

The scientific proof that man was intended to be a nose-breather is deduced not only from the ill-effects resulting from mouth-breathing, but also from the important physiological functions that the nose performs in the animal economy.

The four principal functions performed by the nose are that of smelling; that of filtering or separating from the air we breathe foreign substances; that of imparting moisture to, and that of modifying the temperature of, the respired air.

The sense of smell performs a most important physiological function in protecting us from the poisonous emanations that contaminate the air. Without the sense of smell, the absence of which in our cities might frequently be regarded as desirable, we might unconsciously fail to be warned against unsanitary conditions, such as the escape of illuminating gas in our rooms, coal gas from our furnaces, noxious gases from our sewers, all of which are deadly poisons, as illustrated by the frequent deaths from such causes. Thus when the sense of smell is destroyed by diseased conditions, or the nasal passages are obstructed, we not only